Diversity and Equality in Health and Care 2014;11:275–6

Did you see?

Why mental health matters to global health, Vikram Patel, Transcultural Psychiatry 2014 0(0):1–14

Riya Elizabeth George
University of Leicester

Global health can be defined as 'placing a priority on improving health and achieving equity in health for all people worldwide' (Koplan *et al*, 2009). Global Mental Health (GMH) is a distinctive field in that its research priorities are determined by the burden of health problems and it is rooted in the principles of global health. Its driving philosophy is equity, and it aims to ensure fairness in the distribution of mental healthcare within and between populations and actively seeks to learn from different countries. In this paper Patel directly responds to the common criticisms invoked regarding GMH which are: (i) the lack of biological validity in psychiatric diagnostic categories; (ii) the superiority of social determinants in mental health disorders – overarching individualised biomedical healthcare; (iii) the biased interests of the pharmaceutical industry in GMH; (iv) the assumptions and claims that GMH is allegedly practicing medical imperialism.

Three underlying assumptions dictate GMH's approach and practice (Patel, 2003). Firstly, it accepts the universality of mental illness and claims that Western formulated psychiatric disorders are associated with the same demonstrable pathology and experience globally. Secondly, it assumes the concept of syndromal invariance; the supposition that core features of psychiatric syndromes do not vary between cultures. Finally, it supports the validity of diagnostic categories as universal constructs, although refinements can be made. This new discipline of study has attracted increasing debates and challenges to the central assumptions made by Patel in his paper, such as the principle that Western notions of mental disorders can be translated meaningfully to other contexts (Summerfield, 2013). Patel's article is also important in stimulating discussions about the concepts of 'equality' and 'diversity' and whether they are mutually compatible.

The core intention of GMH to alleviate the vast inequalities in mental health worldwide is shared by a diverse range of stakeholders. 'Equality' is a widely acknowledged notion in healthcare policy. However, there are ongoing debates as to how to better articulate this concept. Critics have often questioned the origins and measures of figures GMH reports regarding mental health inequalities (Summerfield, 2012; Swartz, 2012). The association between mental ill health and disability is well recognised, and globally exemplified through the metrics of disability adjusted life years. Approximately 7% of the global health burden is attributed to mental disorders (Murray *et al*, 2012). It is unclear, in GMH, how the term 'equality' is used, although it appears to equate with advocating equal opportunities in receiving mental healthcare. In addition, how GMH defines 'need' is elusive, Culyer (1993) claims 'capacity to benefit' is better suited than 'need' (Culyer and Wagstaff, 1993).

Culyer and Wagstaff (1993) divide 'equality' into two simple classifications: horizontal equity, meaning persons with equal need should be treated the same, and vertical equity, implying persons with greater need should be treated differently than those with lesser needs. In reference to Western settings, the mental healthcare needs of Black and Minority Ethnic (BME) communities are of particular concern. BME populations have a disproportionate burden of mental illness and remain under-represented in mental health research. Current research appears to advocate horizontal as opposed to vertical equity. Ethnographic research has revealed differences in the presentation, attribution, classification and prognosis of mental disorders between different cultural groups and the need for service provision to be cross-culturally appropriate (Bhui and Olajide, 1999). However, mainstream psychiatric literature primarily emphasises cross-cultural similarities. The principle of global knowledge appears unbalanced as much of the evidence regarding mental healthcare, interventions, treatments and assessments emanates from the West.

The challenge is to demonstrate that increasing the availability of Western-type mental healthcare in non-Western settings equates to meeting the needs of diverse cultural groups. The current evidence-base regarding treatment efficacy for mental disorders in the West is contested and inconsistent and therefore raises the question of whether any standard of mental

health be defined universally (Summerfield, 2012). There is a plethora of evidence signifying lower rates of satisfaction, poorer health outcomes and a convincing perception of mental-health services' inability to meet the needs of BME communities in Western settings (Bhui and Sashidharan, 2003). Applying Western models of mental health may be inappropriate and unresponsive to the needs of culturally diverse groups. Yet Patel argues that, when assessment measures and diagnostic criteria are contextually adapted and culturally appropriate, the capacity to benefit individuals is achievable.

'Diversity', defined as recognising and valuing differences in its broadest sense, challenges the current practice of equality; treating individuals the same regardless of differences. It undermines the assumption that applying the same practice is generally valid to all persons, and that equal care results in equal outcomes (Dogra and Karim, 2005). Definitions of 'equality' and 'diversity' in health policy appear restrained by legalistic ideologies and mutual incompatibility: 'equitable' care does not mean the same care. While public healthcare may be about services to groups of the population, clinical care is about service provision to individuals (Dogra and Carter-Pokras, 2005). Evidence from Western settings indicates, although the 'we treat everyone the same' approach is well intended, BME patients may require different approaches to care to ensure comparable health outcomes and fulfil this notion of vertical equity compared to the general population.

Mental disorders are multifactorial, their aetiology is heterogeneous. Environmental and social factors are powerful determinants in the onset, progression and recovery of mental disorders (Bhugra and Bhui, 2001). Mental disorders are not confined to Western borders, despite differences in presentation and terminology. Critics have argued social, cultural and economic determinants of mental disorders hold far more explanatory power than biological determinants, especially in developing countries.

Patel (2014) asserts that expertise and principles from other fields including cultural psychiatry and social science have been influential in the development of GMH. His article is one of the few to address the criticisms of the field head on. In doing so, several issues are raised and maybe the most important point is that there is a need for cultural psychiatry and GMH to work together as equal siblings in order for success to be achieved and perhaps for cultural psychiatry to have a stronger voice. This would enable the teachings of transcultural psychiatry to be utilised more effectively in GMH.

REFERENCES

Bhugra D, Bhui K (2001) *Cross-cultural psychiatry: A practical guide*: London: Aroid.

Bhui K, Olajide D (1999) *Mental health service provision for a multi-cultural society*. London: WB Saunders.

Bhui K, Sashidharan SP (2003) Should there be separate psychiatric services for ethnic minority groups. *British Journal of Psychiatry* 182:10–12.

Culyer AJ, Wagstaff A (1993) Equity and equality in health and healthcare. *Journal of Health Economics* 12(4):431–457 dx.doi.org/10.1016/0167–6296(93)90004-X

Dogra N, Carter-Pokras O (2005) Stakeholder views regarding cultural diversity teaching outcomes: a qualitative study. *BMC Medical Education* 5(37).

Dogra N, Karim K (2005) Diversity training for psychiatrists. *Advances in Psychiatric Treatment* 11:159–67.

Koplan JP, Bond TC, Merson MH *et al* (2009) Towards a common definition of global health. *Lancet* 373(9679): 1993–1995. dx.doi.org/10.1016/s0140–6736(09)60332–9

Murray CJ, Vos T, Lozano R *et al* (2012) Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 380(9859):2197–2223. dx.doi.org/10.1016/s0140–6736(12)61689–4

Patel V (2003) Cultural issues in measurement and research. *Practical Psychiatric Epidemiology*. US: Oxford University Press.

Summerfield D (2012) Afterword: Against 'global mental health'. *Transcult Psychiatry* 49(3–4):519–530. dx.doi.org/10.1177/1363461512454701

Summerfield D (2013) 'Global mental health' is an oxymoron and medical imperalism. Why do we assume that western notions of psychiatry translate to other settings. *British Medical Journal* 346(f3509):1–2.

Swartz L (2012) An unruly coming of age: The benefits of discomfort for global mental health. *Transcult Psychiatry* 49(3–4):531–538. dx.doi.org/10.1177/1363461512454810

ADDRESS FOR CORRESPONDENCE

Riya Elizabeth George, Greenwood Institute of Child Health, Westcotes House, Westcotes Drive, Leicester LE3 0QU. Email: reg18@leicester.ac.uk